STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175169	A. BUILDING _____ B. WING _____	09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COFFEYVILLE REGIONAL MEDICAL CENTER SNF	1400 W 4TH PO BOX 850 COFFEYVILLE, KS 67337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This Requirement is not met as evidenced by: The facility had a census of 13 residents. The sampled residents included 3 reviewed for other skin issues. Based on observation, interview and record review the facility failed to adequately assess to provide necessary cares and services for the 3 sampled residents including; failure to monitor bruising on 2 residents (#18 and #32) and failure to monitor a skin tear for 1 resident (#83). Findings included: - The 14 day MDS (minimum data set) for resident #18, dated 08/05/2015, documented an admission date of 07/23/2015. The MDS indicated the resident had BIMS (brief interview of mental status) score of 15, indicating cognitively intact, and without any behaviors noted. The resident needed limited assistance with dressing and personal hygiene and extensive assistance with bed mobility, transfers, and toilet use. The resident was documented as being at risk for pressure ulcers, but lacked documentation of any other skin issues.	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 309	Continued From page 1 The 60 day MDS (minimum data set), dated 08/22/2015, documented the same information as the 14 day MDS. The care plan dated 07/28/2014, lacked direction for the staff to monitor the resident's bruising. The Skilled Daily Assessments, completed, from 08/27/2015 through 09/1/ 2015, documented the resident was alert times 3 with occasional confusion. The resident's skin was documented as being warm and dry with color that was in normal limits for the resident's race, the resident did not have any intravenous catheter (IV), and no significant medication changes. The skilled Daily Assessment sheets lacked any information regarding the color, measurements or status of the bruising to the resident's right arm. The Skin Risk Assessment scale documented on 08/30/2015 at 10:03 PM, included the resident's score was 12, which indicated a high risk for impaired skin integrity. The Admission and Weekly Skin Assessments, dated 07/30/2015, documented no wounds. On 08/20/2015, the resident had bruising on the right and left lower legs, and on both arms and both hands. On 08/27/2015, the assessment documented no new wounds. On 08/27/2015 at 9:27 AM, observation revealed the resident had a large purple bruise on the left arm, measuring approximately 4 by 2 inches. The area remained without change when observed again on 09/02/2015 at 9:00 AM. On 09/01/2015 at 6:50 AM, Direct care H advised the resident had bruising, but most of the the	F 309		

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F 309	Continued From page 2 bruising was from IVs. On 09/01/2015 at 7:00 AM, License nursing staff E advised when a resident has a skin issue, such as skin tears or bruising, staff take a picture and documented the measurement. When the residents have bruising a picture would be taken and staff would document it on the wound assessment. Staff E further advised the resident had a large bruise on his/her arm. On 09/01/2015 at 1:15 PM, the resident advised that he/she would be going to another facility soon and did not recall how or when he/she got the bruise on his/her arm, but his/her skin was very thin. On 09/02/2015 at 10:43 AM, Administrative nursing staff B, advised that at this time the facility did not have a policy and procedure in place to monitor bruising, skin tears or pressure ulcers of the residents. No policy was available to instruct staff related to wounds, skin tears or bruising at this time. The facility failed to monitor bruising for this dependent resident of the facility. - The 5 day MDS (minimum data set), dated 08/27/2015, for resident #83, documented an admission date of 08/21/2015. A BIMS (brief interview of mental status) score of 15, which indicated the resident was cognitively intact, needed extensive assistance with bed mobility, transfers, dressing, and toilet use. The resident was at risk for pressure ulcers and had surgical wounds. The care plan, dated 08/24/2015, lacked any	F 309		

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F 309	Continued From page 3 instructions for the staff to monitor or assess the skin tear. The Skin Risk Assessment Scales, dated 08/21/2014, 08/24/2015 and 08/26/2015, documented the resident was rarely moist, with slightly limited sensory perception, very limited mobility risk, was a nutrition risk, and a skin risk. The assessment scores of 20, 14, and 13 points, all indicated a moderate skin risk level. The medical record lacked any nursing admission or weekly skin sheets documenting any wounds. The electronic record contained a picture of the resident's left forearm, dated 08/26/2015 at 9:30 PM, which revealed a purple round bruise with a skin tear at the top of the bruise. The exact size was not obtainable as it was unknown if picture was enlarged or not. The Adult Admission Physical Assessment, dated 08/21/2015 at 4:02 PM, documented no skin problems and with normal color. On 8/27/15 at 7:33 AM, observation revealed the resident had a 3 centimeter in diameter purple area, with a scabbed area around the edge approximately 3 centimeter in length. The area was well approximated, and with pink skin around the scab. The resident stated that he/she had obtained the skin tear when he/she fell. On 09/01/2015 at 7:00 AM, License nursing staff E advised when a resident has a skin issue, such as skin tears or bruising, staff take a picture and documented the measurement. When the residents have bruising a picture would be taken and staff would document on the wound assessment. Staff E further advised the resident	F 309		

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F 309	Continued From page 4 had large bruising on his/her arm. On 09/02/2015 at 10:43 AM, Administrative nursing staff B, advised that at this time the facility does not have a policy and procedure in place to monitor bruising, skin tears or pressure ulcers. On 09/02/2015 at 8:00 AM, Administrative nursing staff B advised the nurses notes were charted by exception and the wounds were tracked on a wound assessment sheet and with pictures in the computer. No policy was available addressing wounds, skin tears or bruising at this time. The facility failed to monitor bruising with skin tear, for this dependent resident. - Resident #32 admitted to the unit on 7-23-15, with diagnoses which included enthesopathy of hip (surgical repair of hip), anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues), and morbid obesity (when the excess body fat becomes a danger to your overall health). The admission MDS (minimum data set), dated 8-5-15, recorded the resident with a BIMS (brief interview for mental status) of 15, indicating cognitively intact. The resident had no behaviors or psychosis and required limited assistance of 1 for bed mobility, toilet use and personal hygiene. The resident had no history of falls and had not experienced any falls since admission to the hospital.	F 309		

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F 309	Continued From page 5 The CAA (care area assessment), dated 8-5-15, documented the resident had a reverse total shoulder surgery recently and is currently non-weight bearing. The resident required assistance to get into bed and had an immobilize in place on his/her arm. The resident worked with physical and occupational therapy to get strength and to return home. The CAA also documented the resident was at a low risk for skin issues. The care plan, dated 7-26-15, had nothing in it regarding skin issues. Review of the resident's medical record revealed a 7/23/15 skilled nursing admission and weekly skin assessment which acknowledged a bruise to the resident's right forearm. There was no other documentation regarding the bruise to the resident's arm. On 8-27-15 at 12:57 p.m., the resident stated the bruise on his/her right forearm was caused by IV sticks while in the hospital. On 9-1-15 at 7:12 a.m., licensed nursing staff E stated, he/she was unsure of what caused the bruising on the resident's arm, but believed it was caused by IV sticks. Staff would take a photo of any skin issues when the resident admitted to the unit. Staff would measure and document the skin area and document on the wound assessment record. On 9-1-15 at 7:38 a.m., observation revealed the bruise remained to the resident's right forearm. The bruise was a lighter shade of purple than on 8-27-15. On 9-1-15 at 6:46 a.m., direct care staff H stated,	F 309		

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F 309	Continued From page 6 that if a resident had a new skin area, he/she would notify the nurse. Staff H stated they were unsure of what had caused the bruising to the resident's arm. On 9-1-15 at 9:21 a.m., direct care staff I stated, that if he/she saw some sort of skin issue on a resident, they would notify the nurse. The nurse would then document and contact the resident's doctor. On 9-1-15 at 4:03 p.m., licensed nursing staff C stated, the nursing admit and weekly skin assessments were the only documentation available of the bruising to the resident's right forearm. There were no measurements available and the bruise was only documented on the one weekly assessment. On 9-3-15 at 9:10 a.m., administrative nursing staff B stated, measurements of wounds are under wound interventions. Pictures are taken and kept in "other reports". Staff B was not able to locate any documentation for this resident's bruised forearm. On 09/02/2015 at 10:43 AM, Administrative nursing staff B, advised that at this time the facility did not have a policy and procedure in place to monitor bruising, skin tears or pressure ulcers of the residents. The facility failed to monitor bruising for this resident.	F 309		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329		

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F 329	Continued From page 7 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: - The H & P (history and physical) assessment for resident #10, dated and signed on 07/01/2015, documented the following diagnoses as Dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (elevated blood pressure), hyperlipemia (condition of elevated blood lipid levels), diverticulosis (pouch like herniations through the muscular layer of the colon), macular degeneration (progressive deterioration of the retina), lower gastrointestinal bleed (bleeding into the stomach and/or digestive tract), degenerative arthritis(inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement) avulsion fracture (broken bone) of the right lateral malleolus (part of the ankle), acute	F 329		

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F 329	Continued From page 8 small subdural hematoma (collection of blood on the surface of the brain). The 14 day/admission MDS (minimum data set), dated 07/10/2015, documented an admission date of 06/26/2015, BIMS (brief interview of mental status) score of 14, mood score of 00, and no behaviors noted. The resident received PRN (as needed) pain medication for occasional mild pain and antidepressant medication. The Psychotropic Drug Use CAA (care area assessment), dated 07/14/2015, documented the resident was on a maintenance dose of Celexa and was not showing any signs of depression, but noted baseline dementia. The Pain CAA, dated 07/14/2015, documented the resident had a right foot fracture, related to a fall at home and occasionally complained of pain to his/her right foot for which Lortab was administered. The nurse's note, dated 07/16/2015 at 4:06 PM, documented the resident was depressed and crying. A telephone order from the doctor was received ordering Xanax 0.25 mg (milligram), twice daily, PRN and to increase Celexa from 10 mg to 20 mg. The nurse administered to the patient Xanax 0.25 mg and PRN Lortab for pain, patient rated pain 5/10. The resident had the following orders for medications and received as ordered per the July and August, 2015 MAR (medication administration order): 08/26/2105 Haldol, 1 mg , PO (by mouth), BID (twice day), which lacked diagnosis. 08/07/2015 Xanax, 0.25 mg, PO, BID at 10AM	F 329		

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F 329	Continued From page 9 and 3 PM, which lacked diagnosis. 07/17/2015 Celexa, 20 mg, daily, PO, which lacked diagnosis. 07/10/2015 Caltrate Plus 1 tablet, BID, PO, which lacked diagnosis 06/27/2015 Ocuvite, 1 tablet, daily ,PO, which lacked diagnosis. 06/27/2015 Aricept, 10 mg, PO, daily, which lacked diagnosis. 06/27/2015 Metamucil, daily, PO, one each, which lacked diagnosis. 06/27/2015 Lisinopril, 20 mg, daily, PO, which lacked diagnosis. 06/26/2015 Xalatan, 1 drop each eye at HS (hours of sleep), which lacked diagnosis. Observation, on 08/31/2015 at 8:15 AM, revealed the resident positioned in the recliner having breakfast, feeding self independently. He/She was alert and oriented to self and no signs of behaviors or pain. Observation, on 08/31/2015 at 1:47 PM, revealed the resident positioned in his/her chair, dressed for the day and visiting with family. The resident stated he/she had to have another x-ray and would get to go home soon. The resident was alert, oriented, no behaviors, and no signs of pain or distress. On 08/31/2015 at 1:53 PM, Administrative nursing staff B advised, the facility did not have the diagnoses on the MARs or the order sheets. The doctors did not put the diagnosis on the medications orders. On 09/03/2015 at 9:30 AM, Administrative nursing staff B advised, he/she visited with the pharmacist about why there are no diagnoses on the medications that were ordered for the	F 329		

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residents. At this time there were no diagnoses on the MARs or anywhere in the chart unless it was a PRN med.

The facility did not provide a policy in reference to having diagnosis on the orders for medications.

The facility failed to ensure no unnecessary medications for this resident with the failure to document the diagnosis for the medications ordered by the physician for administration for this resident of the facility.

- The admission note, signed and dated on 08/26/2015, for resident # 80, documented the following diagnoses as multiple MRSA (methicillin resistant Staphylococcus aureus) abscesses (cavity containing pus and surrounded by inflamed tissue) in the buttocks area post I & D (incision and drainage) with an outpatient antibiotic failure, candida (a genus of yeast) intertrigo (an erythematous irritation of opposing skin surfaces caused by friction, moisture, warmth or sweat retention) of the peri area, hematuria (blood in the urine), hypertension (elevated blood pressure), hypokalemia (low level of potassium in the blood), and hyperlipdemia (condition of elevated blood lipid levels).

The medical record contained only an entry MDS (minimum data set) assessment as the resident was admitted on 08/26/2015 and it was not due by date of the survey.

The resident had the following physician orders for medications and received as ordered per the August, 2015 and September, 2015 MAR (medication administration order):

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F 329	Continued From page 11 09/01/2015 Multivitamins/mineral Centrum Silver, which lacked a diagnosis. 08/30/2015 Senokot-S, which lacked a diagnosis 08/30/2015 Dulcolax, PRN (as needed), which lacked a diagnosis. 08/30/2015 Milk of Magnesia, PRN, which lacked a diagnosis. 08/27/2015 Fluconazole, which lacked a diagnosis. 08/27/2015 Lovenox, which lacked a diagnosis. 08/27/2015 Lipitor, which lacked a diagnosis. 08/26/2015 Ceftaroline Fosamil, which lacked a diagnosis. 08/26/2015 Lodaform packing strips, daily, which lacked a diagnosis. The nursing note, dated 08/31/2015 at 1:23 PM, documented IV (intravenous)Teflaro was administered late due to the resident not having IV accessibility. Review of the August, 2015 and September, 2015 MAR/TAR for the resident's admission, revealed no gaps in administration and medications given as ordered. On 08/31/2015 at 8:30 AM, observation revealed the resident positioned in bed. The resident advised he/she can reposition self in the bed and tried to stay off the sores as much as possible. He/She advised the sores became infected and the doctor drained them and they are healing and doing much better now. On 08/31/2015 at 4:00 PM, observation revealed the resident positioned on his/her left side and License nursing staff C changed the bandages to the wounds on his/her buttocks and thigh after washing with normal saline, then packed with Lodoform ribbon packing strips.	F 329		

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F 329	Continued From page 12 On 09/01/2015 at 7:00 AM, License nursing staff E, reported the resident had I & D and the wounds were packed with Lodaform strips daily and PRN (as needed). On 08/31/2015 at 1:53 PM, Administrative nursing staff B advised, the facility does not have the diagnosis on the MARs or order sheets for the medications. The doctors do not put the diagnosis on the medications on this unit. On 09/03/2015 at 9:30 AM, Administrative nursing staff B advised, he/she visited with the pharmacist about why there are no diagnoses on the medications that were ordered for the resident. At this time there were no diagnoses on the MARs or anywhere in the chart unless it is a PRN med. The facility did not provide a policy in reference to having diagnosis on the orders for medications. The facility failed to ensure no unnecessary medications with the failure to document the diagnosis for the resident's medications, ordered by the physician for administration for this resident of the facility. - The H & P (history and physical examination) for resident #83, dated and signed on 08/18/2015, documented the following diagnoses as history of CVA (stroke, sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), diabetes Mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), left side hemiparesis (muscular weakness of one	F 329		

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F 329	Continued From page 13	F 329		

half of the body), gastric bypass in 2003, AICD (automatic Implantable Cardioverter Defibrillators) and the discharge summary, dated 08/28/2015, documented an additional diagnoses of left hip fracture.

The 5 day MDS (minimum data set), dated 08/27/2015, documented an admission date of 08/21/2015, BIMS (brief interview of mental status) score of 15, indicating cognitively intact, and no behaviors noted. The resident required extensive assistance with bed mobility, transfers, dressing, and toilet use. The resident was documented as having pain almost constantly, rated at a 10 and had surgical wounds. The medications listed as the resident received on 7 days of the look back period was an antianxiety, and on 6 days received as an antidepressant and a diuretic.

The resident had the following physician orders for medications and received as ordered per the August, 2015 MAR (medication administration order):

08/25/2015 Miralax, 17 grams, PO (by mouth), which lacked a diagnosis.
08/25/2015 Dulcolax, once, 10 mg (milligram), lacked a diagnosis.
08/24/2015 Calmoseptine, 113 gram, once, lacked a diagnosis.
08/23/2015 Juven, BID (twice a day), dietary supplement, lacked a diagnosis.
08/22/2015 Brintellix, 10 mgs, lacked a diagnosis.
08/22/2015 Lasix, 40 mg, daily, PO, lacked a diagnosis.
08/22/2015 Plavix, 75 mg ,PO, daily, lacked a diagnosis.
08/22/2015 Asprin, 81 mg, daily, PO, lacked a diagnosis.

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COFFEYVILLE REGIONAL MEDICAL CENTER SNF	1400 W 4TH PO BOX 850 COFFEYVILLE, KS 67337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 14 08/22/2015 Centrum Silver, 1 tablet daily, PO (by mouth), lacked a diagnosis. 08/22/2015 Ferrous Gluconate, 325 mg (milligram), daily, lacked a diagnosis. 08/22/2015 Caltrate Plus vitamin D, 2 tablets, PO, daily, lacked a diagnosis. 08/22/2015 Lisinopril, 5 mg, daily, lacked a diagnosis. 08/22/2015 Synthroid, daily, PO, 150 mcg (micrograms), lacked a diagnosis. 08/22/2015 Digoxin, 01.25 mg, daily, PO, lacked a diagnosis. 08/22/2015 Prilosec, 40 mg, daily, PO, lacked a diagnosis. 08/21/2015 Colace, 100 mg, BID, PO, lacked a diagnosis. 08/21/2015 Remeron, 30 mg, PO, lacked a diagnosis. 08/21/2015 Colace, 100 mg, BID, PO, lacked a diagnosis. 08/21/2015 Xalatan, HS (hours of sleep), instill one drop into each eye, lacked a diagnosis. 08/21/2015 Coreg, 6.25 mg, BID, PO, lacked a diagnosis. 08/21/2015 Lipitor, 40 mg, HS (hours of sleep), PO, lacked a diagnosis. 08/21/2015 Tylenol, 325 mg, every 4 hrs, PO, lacked a diagnosis. The Physician Progress note, dated 08/25/2015 at 08:43 AM, documented the patient complained of no bowel movement for several days and continued with complaint of left hip pain, additional treatment today for constipation. The Skilled Nursing Flow Sheets, dated 08/21/2015 through 08/27/2015, documented the resident alert times 3, had hip pain rated between 4 to 10, administered PRN pain medication and PRN medication for anxiety.	F 329		

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F 329	Continued From page 15 Observation, on 08/27/15 at 7:33 AM, revealed the resident had a 3 CM (centimeter) in diameter purple area, with a scabbed area around 3 cm in length. The resident stated that he/she obtained the skin tear when he/she fell and broke her hip. On 08/31/2015 at 1:53 PM, Administrative nursing staff B advised, the facility does not have the diagnosis on the MARs or order sheets. The doctors do not put the diagnosis on the medications orders. On 09/03/2015 at 9:30 AM, Administrative nursing staff B advised, he/she visited with the pharmacist about why there are no diagnoses on the medications that were ordered for the residents. At this time there were no diagnoses on the MARs or anywhere in the chart unless it is a PRN med. The facility did not provide a policy in reference to having diagnosis on the orders for medications. The facility failed to ensure no unnecessary medications with the failure to document the diagnosis for this resident's medications, as ordered by the physician for administration for this resident of the facility. The facility identified a census of 13 residents. The sample of 10 residents, included 5 residents reviewed for unnecessary medications. Based on record review and interview, the facility failed to ensure 5 of these 5 residents (#32, #85, #83, #80, #10) remained free from unnecessary	F 329		

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F 329	Continued From page 16	F 329		

medications related to the failure to obtain appropriate diagnoses for the 5 resident's scheduled medications.

Findings included:

- Resident #85 admitted to the facility on 8-21-15, with diagnoses which included depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness) and arthritis (Arthritis-inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement).
The 5-day MDS (minimum data set), dated 8-28-15, documented the resident had a BIMS (brief interview for mental status) of 15, indicating the resident was cognitively intact. The resident's mood score was 0, indicating no depression. The resident required extensive assistance of two staff for bed mobility, transfers and toilet use.

The care plan, dated 8-21-15, instructed staff the resident was at risk for falls and was non-weight bearing due to a recent fracture of their right ankle.

No CAAs (care area assessment) available for this resident due to admission date of 8-21-15.

Physician orders dated 8-21-15, included;
Colace 100 mg (milligrams), po (by mouth), QD (every day), ordered on 8-22-15.
Detrol LA, 4 mg, po, QD, ordered on 8-22-15.
Centrum Silver, 1 po, QD, ordered on 8-22-15.
Lotensin, 10 mg, po, QD, ordered on 8-22-15.
Norvasc, 2.5 mg, po, QD, ordered on 8-22-15.
Potassium Chloride, 20 meq, po, QD, ordered on 8-22-15.

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F 329	Continued From page 17 Omeprazole, 40 mg, po, QD, ordered on 8-22-15. Gabapentin, 00 mg, po, TID, ordered on 8-21-15. Lantus, 21 units, SQ (sub-Q), HS (hour sleep), ordered on 8-21-15. Klonoppin, 0.5 mg, po, BID (twice a day), ordered on 8-21-15. Caltrate Plus, 1 po, BID, ordered on 8-21-15. Elavil, 25 mg, po, HS, ordered on 8-21-15. Lipase/Protease/Amylase, 1 po, TID (three times per day), on Wednesdays/Mondays, ordered on 8-21-15. Glucotrol, 10 mg, po, BID, ordered on 8-21-15. Review of the resident's menical record revealed there were no diagnoses for the resident's scheduled medications. On 8-31-15 at 12:29 p.m., administrative nursing staff B stated, the diagnoses are not listed on the MAR (medication administration record) along with the medication. The doctors do not put the diagnoses on the medications in the skilled unit as they do on the acute side of the hospital. Staff B stated the in-house pharmacist reported at this time there are no diagnoses on the MARs or anywhere in the chart unless it is an as needed medication. The unit had no policy or procedure regarding the need of diagnoses on medications in the resident's medical records. The facility failed to ensure no unnecessary medication with the failure to provide diagnoses for this resident's medications. - Resident #32 admitted to the unit on 7-23-15, with diagnoses which included enthesopathy of hip (surgical repair of hip), anemia (condition without enough healthy red blood cells to carry	F 329		

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F 329	Continued From page 18 adequate oxygen to body tissues), and morbid obesity (when the excess body fat becomes a danger to your overall health). The admission MDS (minimum data set), dated 8-5-15, recorded the resident with a BIMS (brief interview for mental status) of 15, indicating cognitively intact. The resident had no behaviors or psychosis and required limited assistance of 1 for bed mobility, toilet use and personal hygiene. The CAA (care area assessment), dated 8-5-15, documented the staff needed to encourage the resident to use the call light when he/she needed to get up, related to altered balance and sleep aide usage. The care plan, dated 7-26-15, documented the resident had impaired physical mobility related to surgery and restrictive therapy. The patient would continue to regain mobility and increase independence as tolerated. Physician's orders included the following medications: Selenium, 200 mcg, po (by mouth), QD (every day), ordered on 8-28-15. Silver Sulfadiazine, apply liberally, BID (twice a day), ordered on 7-31-15. Vitamin D, 50,000 units, po, QD, ordered on 7-29-15. Zinc Gluconate, 50 mg (milligrams), po, QD, ordered on 7-24-15. Lasix, 40 mg, po, QD, ordered on 7-24-15. Vitamin C, 1,000 mg, po, QD, ordered on 7-24-15. Vitamin B complex/vit c/folic acid, 1 po, QD, ordered on 7-24-15. Potassium Chloride, 10 meq, po, QD, ordered on 7-24-15.	F 329		

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F 329	Continued From page 19 Thyroid, 60 mg, po, Q a.m. (every morning), ordered on 7-24-15. Inderal, 40 mg, po, BID, ordered on 7-23-15. Colace, 100 mg, po, BID, ordered on 7-23-15. Caltrate Plus, 1 tab, po, BID, ordered on 7-23-15. Review of the resident's medical record revealed there were no diagnoses for these resident's scheduled medications. On 8-31-15 at 12:29 p.m., administrative nursing staff B stated, the diagnoses are not listed on the MAR (medication administration record) along with the medications. The doctors do not put the diagnoses on the medications in the skilled unit as they do on the acute side of the hospital. Staff B stated the in-house pharmacist reported at this time there are no diagnoses on the MARs or anywhere in the chart unless it is an as needed medication. The unit had no policy or procedure regarding the need of diagnoses on medications in the resident's charts. The facility failed to ensure no unnecessary medications with the failure to provide diagnoses for this resident's medications.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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This Requirement is not met as evidenced by:
The facility reported a census of 13 residents. Based on observation and interview, the facility failed to store, prepare, and serve food under sanitary conditions to prevent the spread of food borne illnesses to the residents of the facility.

Findings included:

- On 9-1-15 at 11:01 a.m., during the kitchen environmental tour of the dietary department, the following areas of concern were noted:

1.) The floor underneath the dishwasher had a thick white/brown colored build-up. There was also food built-up along the baseboard underneath the sink.

2.) There was a build-up of food particles along the parameter of the kitchen floor.

3.) There were 3 broken tile on the wall next to the ice cream machine.

4.) The hand-washing sink was stained brown.

5.) The casing to the pipes going into the freezer was held together with duct tape at the bottom.

6.) Five plastic cutting boards contained deep grooves making them impossible to sanitize.

7.) The top of the orange plastic trash can had food splatters over it.

8.) The wall behind the tilt skillet had food and grease splatters.

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F 371	Continued From page 21 9.) Ten cookie sheets lacked the protective inside coating. Dietary staff G reported this was caused by oxidation of the chemical in the dish machine. 10.) The 12 inch skillet had a heavy build-up of dark discolored substance on the inside. 11.) A 6 inch skilled had a heavy build-up of the dark discolored substance on the inside. 12.) A 6 inch skillet's inside protective coating was chipping away. 13.) The back of the stove top had grease build-up. On 9-2-15 at 11:23 a.m., dietary staff G stated, the areas mentioned were supposed to be cleaned on a daily basis, but obviously it is not getting done. Staff G stated that he/she did more of the clinical side of the kitchen while dietary staff F was responsible for making rounds in the kitchen to ensure the staff cleaned properly. The facility failed to store and prepare foods under sanitary conditions for the residents of the facility.	F 371		